ORIGINAL

CABINET FOR HEALTH AND FAMILY SERVICES
ADVISORY COUNCIL FOR MEDICAL ASSISTANCE

May 25, 2018
10:00 A.M.
Room 125
Capitol Annex
Frankfort, Kentucky

MEETING

APPEARANCES

Elizabeth Partin
CHAIR

Chris Carle
Julie Spivey
Steven Compton
Melody Stafford
Jay Trumbo
Ashima Gupta
Bryan Proctor
Sheila Currans
Susie Riley
William Schult
Stacey Watkins
Susan Stewart
Peggy Roark
COUNCIL MEMBERS PRESENT

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AGENDA

AGENDA
(Continued)

DR. PARTIN: We will call this meeting to order. First of all, we'd like to welcome our new member, Bryan Proctor, and our returning member, Peggy Roark and thank Eric Wright for his service.

Next on the agenda is approval of minutes from January and March. If you all remember, we did not approve the minutes from January at our last meeting because some people had not had an opportunity to read them.

So, having said that, do we have a motion to accept those minutes?

MR. CARLE: So moved.

DR. PARTIN: A second?

MR. SCHULT: Second.

DR. PARTIN: Any discussion? All in favor, say aye. Any opposed? So moved.

Old Business. Medically frail, and we received information about that in an email from Sharley and I just have a couple of comments.

I didn't print out the whole thing because it was rather long but the piece I printed was the application and there were two attachments in that email and the second attachment listed all of the different types of disorders that

could be qualified as medically frail.

And on K-14 and K-37, Down Syndrome was listed twice, and I didn't know if there was a reason for that or if that was just an error.

DR. LIU: Good morning. Gil Liu, Chief Medical Officer, Kentucky Medicaid.

It sounds like a clerical error. So, I'll go back and check that. Thank you for pointing that out.

DR. PARTIN: Okay. And, then, in Section (b) under Mental Disorders, and then it lists Intellectual Disorders, would the mentally challenged be qualified under that as medically frail, especially those who are mentally challenged. They're able to live on their own in the community but they are not able to hold a job or do anything like that other than maybe a few odd jobs on a farm or something like that, something very simple?

DR. LIU: A couple of comments. One is that receipt of Social Security disability insurance or SSI is an automatic qualifier for medically frail status. We'll get that automatically through shared governmental information.

The clinician attestation, when a provider marks that a patient of theirs has an

intellectual disability, that will be factored into an algorithm that looks at both individual diagnoses that are what we would call high-severity automatic qualifiers and, then, lower-severity conditions that might in combination designate somebody as frail.

So, in both instances, having an intellectual disability is a consideration, and the more severe instances is the automatic qualifier. It may be factored in as a co-occurring condition to contribute to a score that would exceed a threshold and result in a designation.

So, I'm going on a little bit at length but, yes, it depends on kind of the overall picture of the patient as far as what would result in a designation or not.

DR. PARTIN: Okay, and I'm thinking specifically of some patients of mine who are mentally challenged who do live on their own. They're a married couple. One of them can read, the other one can't read but they function okay but they couldn't hold down a job.

DR. LIU: That goes back to the guiding principle for medically frail which is a federal requirement. In general, it says that anytime you do a demonstration project, you need to

identify. Those beneficiaries who need reliable access through the standard benefit plan should not be included in an alternative benefit plan with a demonstration project.

So, intellectual disability is clearly a condition that's considered and qualifying. In many instances, it would be an automatic qualifier. So, it would address what you're bringing up as a concern.

I would go on to say there are also impaired activities of daily living as a set of criteria. So, those may also be relevant in this instance. I would just mention that, too.

DR. PARTIN: Okay. Thank you. Does anybody else have any questions about that?

MR. CARLE: They're still in draft form. So, when do you feel like you're going to have the final rendition?

MS. BATES: We have a call with CMS today to finalize some details and we should hopefully get the answers that we need to produce a final draft. So, I would say tomorrow.

MR. CARLE: Okay. And, then, what are your thoughts as far as communication and roll-out of that final draft?

MS. BATES: So, we obviously will communicate it immediately to our managed care organizations so they can get that out via their websites and their provider communications and, then, we will post it as well. We plan to send it out to those who attended the provider forums that we did across the state and we'll send it to the MAC and the TACs.

MR. CARLE: Okay, but you won't have any specific provider forums related to this?

MS. BATES: I believe that the MCOs were planning to do trainings just about all parts of Kentucky HEALTH. So, this would be included.

MR. CARLE: Thank you.

DR. PARTIN: Any other questions? Thank you. That's all we had under Old Business unless somebody else has something else.

All right. Then, let's move on to the Commissioner.

COMMISSIONER MILLER: Real quick, good morning. I'm going to start from the bottom up, I guess, sort of speak. If you look on the agenda, you have the Other category and we're going to start there first with a 1915(c) update and

I'll come back to the table. I have a few comments to make and then I'll field questions.

MS. HUGHES: Jill, while you're coming up, I forgot to say something to Beth earlier. Kristi Putnam will be a little late getting here today. So, I know you all are probably wanting some information from her, but if we can move her to maybe after the TAC meetings, that would be good for her.

DR. PARTIN: Sure.

MS. HUNTER: Thank you very much, Dr. Partin. Jill Hunter, Deputy Commissioner of Medicaid working under Commissioner Miller. I have with me this morning two of my team members from Navigant. They're both working with us, as well as a large group of individuals from Navigant working with us on the 1915(c) waiver redesign and I'll turn this over to them to introduce themselves, tell you what role they play and provide a presentation and we'll remain here for questions after.

MS. HUGHES: The presentation is in your packet.

MS. HUNTER: Thank you, Sharley. What would we do without Sharley is usually my question of the day.

MR. GERLING: I'm Jason

Gerling, a gerontologist on Navigant's Long-Term Services and Supports' team. I'm the Project Manager here for the 1915(c) assessment and redesign project.

MR. WHITEMAN: And I'm Randy Whiteman, Associate Director with Navigant Consulting and Engagement Director for the waiver assessment project.

MR. GERLING: Actually, you kick it off.

MS. HUNTER: I love it when I know that I kick it off and they tell me that I do.

So, a little bit about what's going on. You've heard me talk passionately about this group before. So, you get to hear a few more minutes with Jill about 1915(c) waiver redesign.

As you know, several months back, it's been actually a year, twelve months, almost thirteen, we went through the Model Procurement process and successfully hired Navigant Consulting as our vendor for waiver redesign.

For those of you that don't work directly with our waivers, we have six waivers - Michelle P., brain injury, two brain injury waivers, HCB, SCL, Model Waiver II. So, we work with individual s who are varying degrees of either ID,

DD, brain injury, acquired brain injury. Those are the individuals who, as you recall, Medicaid was designed for back in the sixties. So, we're very excited to have the privilege to continue to work with those individuals.

Navigant was the successful vendor when we did the 1915(c) redesign procurement. We have been working almost fourteen months. We have gone through stakeholder sessions, as I've shared with you. We went across the state in the fall. We just finished going across the state here in the spring talking about where we are, where we need to be and how we're going to get there.

So, we've been very excited working with Navigant. The focus area is currently how the staff are doing their work back at our Cabinet, so, not only Medicaid but the agencies that we work with to serve these recipients. So, Medicaid, the Department for Community-Based Services, Aging and Independent Living and Behavioral Health.

While we all sit in an agency together, we historically have worked in silos and we have the opportunity now for this project to work cross agency from the Commissioner level, from the

Secretary level, working with Secretary Meier, Secretary Brinkman, all the way across our agencies in to all the folks that work directly for us, wrapping around these recipients to do the right thing the best we can with what we have at the time.

So, fiscally, sometime over the next six months, we will be doing a rate study but we are also doing an operations study. So, that's a little bit about what we are doing, where we've come and where we're headed.

And at this point, I would like to turn it over to Jason to share where we're headed and where Navigant is. Again, our goals remain consistent. We have a finite amount of funds unless you all have the power to go convince somebody to send me money; and if you can, please do because we'll always take more funds. That makes my finance officer happy. We have a finite amount of funds.

We have a number of people on our waiting lists. Every day, we have individuals waiting to get on these waivers that need services desperately but we are still trying to do the best we can with what we have for those we serve, and keeping in mind every day the providers, the recipients, their families.

I've explained it before and I'll continue to say if Medicaid were to change tomorrow, people situated like me will wake up and probably not need services twenty-four, forty-eight hours, and I'll probably be fine for a couple of days; but if you think of individuals with a brain injury, they will wake up tomorrow and need services the minute the day starts.

So, we're very passionate about doing the right thing, and I appreciate the MAC's support as we continue through this project.

MR. GERLING: So, a little bit about how we've gone about the work that we have proceeded with over the last year or so before we talk about the recommendations that we have recently released in preliminary form.

You will see that there is a slide that outlines the three assessment focus areas and that includes operational redesign, waiver redesign and stakeholder engagement.

Operational redesign is really where we focused on engaging the staff within the Cabinet as well as some additional components of the Cabinet that don't directly administer the waivers but have a very important role in the system. That

would include Kentucky Protection and Advocacy along with the Cabinet's Ombudsman unit.

We conducted over thirty individual interviews with staff. We also have worked with staff throughout the year to do targeted end-to-end assessments of individual work streams to really understand what I refer to as the method to the madness, how the work is really being done on a day-to-day basis so that we can poke holes in that and really help, not just look at efficiencies but really focus on effectiveness to make sure that folks are performing in a way that really reinforces the ultimate goal of the services which is to optimally serve the participants on the waivers.

Within the course of waiver redesign, we really initiated that in this calendar year and as a portion of that exercise have candidly gone line by line through all appendices of all six waivers, cross-comparing contents to really look at the information that's housed in those waivers and to better position the waivers to be (a) more consistent where appropriate, but (b) to really offer a better source of information to providers, participants and other individuals that engage in the system so that when we present updated waivers to CMS, they reflect

national best practices. They fully inform and explain them on how Kentucky plans to administer and oversee their waivers and they will offer what I refer to as the single source of truth for how these waivers need to operate from a policy and procedural standard that everybody can really go back to, including the Cabinet, providers, participants and others.

Last but not least is--did you want to interject?

MR. WHITEMAN: Just to add on to that as well. A lot of that work is really stemming from a lot of the provider focus groups that were conducted in the fall and a lot of what we are hearing in terms of the concerns and the lack of consistency around how one waiver was designed and potentially not solely by design but by nature of when that was written and potentially in a vacuum as compared to when some of the other waivers were written.

And, so, really, the whole goal there is to be able to standardize where standardization makes sense.

MR. GERLING: And, then, last but not least, stakeholder engagement which has been

an enormous part of the process in addition the over--well, the forty focus groups that we conducted with close to five hundred individuals across the state in the fall of 2017.

We just recently went, actually I think it was Tuesday evening wrapped up a series of ten town halls. So, we really have intentionally attempted to engage stakeholders in a way that they had a phased information sequence where we could offer enough information that people could digest it and understand it.

I think at the provider level, that's much easier. A lot of our participants need information in bits and pieces at a time where they can digest it, offer feedback and we can sequence that accordingly; but we've also had and are planning to respond to ensure order a litany of incoming comment and question.

And the intent there is to take all of that collective question and respond to it in one single Frequently Asked Questions' document which will be a living, breathing tool and a resource that can be updated on a continuing basis as we continue to move through this process. So, that's really the nature at a high level of the work that's been done.

Another piece that's been really critical to the trajectory of the project is having goals that the entire governance team within the Cabinet are aligned with that we can use to benchmark how we're going about our work and how we're making decisions.

So, if you will flip to the slide that states Goals for Kentucky's Home- and Community-Based Waiver Programs. These were vetted, and I will also say that beyond just the governance team's review, stakeholder input was factored into how these goals were arrived at, and, additionally, we made adjustments to those goals based on said feedback.

The list is sequenced in order of priority. The must have is feasibility to implement any changes within timeline and budget. Number one is to enhance quality of care to participants. Number two is to maximize consistency in definitions and requirements across the waivers.

Number three is to implement a universal participant assessment and an individualized budget methodology. Number four would be to curb preventable increases in total spend for Home- and Community-Based Services' programs.

I like to caveat for folks and we did this during the town halls that that does not mean within the goal that the Cabinet is stating they don't seek to ever spend more on these services or should not spend more on the services.

It's really just a reflection that there is always an ongoing need to address any waste, fraud and abuse concerns that exist within this segment so that we can make best use of the resources that are available to the Medicaid unit.

Additionally, goal number five is to establish procedures for all wavier management administrative activities. Number six is to diversify and grow the provider network. Number seven is to design services that address participant's community-based needs, including for populations who are under-served or are not served at all by today's waivers.

Number eight is to make provider funding consistent with reasonable and necessary Home- and Community-Based Services' program costs. And number nine is to optimize case management to support person-centered planning and abide by conflict-free case management regulation.

So, that gives you a bit of a

snapshot into the head space of the decision-making and how we're bumping up all of the progress and thought processes that are going into decision-making related to the 1915(c) waivers.

So, I will turn it over to Randy to present a metaphorical comparison to how we're approaching our recommendations that we used to make this as accessible and relevant to folks out in the trenches so that they could really make sense of what we're after here.

MR. WHITEMAN: So, if you look at Slide 8, this is the metaphor that we've been using to really bucket our recommendations and make them--you know, certainly, there's a lot of different areas that are being assessed.

And, so, it was very critically important that we could describe the recommendations in a way that folks across the state were going to be able to resonate with.

And, so, bear with us, folks that don't have the slides here, but for purposes of explaining the metaphor, it's really like building a home.

And, so, we really looked at each of our recommendations in a way as sort of

which ones are foundational, and those being policy and regulatory types of recommendations where improvements needed to be made in order to be able to strengthen the foundation of the home from using that home concept there.

The walls, in terms of looking at the walls, and I think the way that we bucketed the recommendations there was looking at how the services are wrapped around and protect the contents within the home and, so, looking at case management system and well-designed participant-directed services systems for those that choose to self-direct their care.

The roof, the way we bucketed the recommendations under the roof were really the monitoring and oversight, program administrative type of activities that the Cabinet is undertaking. And certainly when those elements are handled well, everything else underneath the home is going to be protected well.

The living room or the living space, that's really, as Jason had mentioned earlier, the internal components within the agency. If you think back to what the focus areas were, the three boxes of the assessment focus areas, that's really

the operational design. So, how they're internally structured and able to provide oversight and program administration would be the living space.

The front yard is really where we presented our recommendations on the stakeholder engagement components and the Cabinet opening up and enhancing transparency around these processes to incorporate stakeholder involvement.

And I think we've certainly taken steps to this point to increase that transparency, but I think really moving forward is we're anticipating targeted stakeholder engagement on an ongoing, continuous basis. Certainly a lot of these key initiatives and decisions are going to be made moving forward.

And, then, lastly the future plans in terms of maintenance, in terms of remodeling, that sort of thing with the home metaphor is really looking at, the way it's being described at this point to folks across the state is we're getting our house in order first and then we're going to be looking at potentially what is being coined as waiver reconfiguration.

And that is not taking place at this point in terms of wait list information or

design of the waivers. That would come down the road once the Cabinet has made its go, no-go decisions on the preliminary recommendations and those have been fully implemented for those that they have decided to move forward with.

So, that's the structure of how we bucketed it and I think it was just important as we lay out, we wanted to cover a high level of the actual recommendations and sort of how they fit into that structure.

MR. GERLING: And I always apologize. They can come across as a bit corny these metaphors, but, candidly, I found them, as somebody who started in case management, explaining something to folks who are vulnerable or may have cognitive or intellectual disabilities, it's really important to make it tangible and resonant to them.

And actually this metaphor helped engage folks in conversation while we were in the town halls. so, even when they didn't agree with us, and folks sometimes don't, I think it was helpful to really engage folks and have some meaningful dialogue.

So, with that, I will walk you in further detail through our recommendations. And,

again, these are preliminary. We're currently in the process of reviewing the feedback that we received from the town halls and will certainly make adjustments as we see necessary.

So, when we talk about the foundation, again, that really speaks to some of the core decision-making methodologies and frameworks that offer essentially a foundation or a stabilization effort for these waivers.

So, first of all, a recommendation would be to standardize the waivers, again, making them as consistent as possible, keeping in mind that there are individual populations with unique needs that may need some type of tweak or a modification to language to really tailor to the needs of that group; but upon our review, we saw that there were some very basic definitions that candidly in our estimation don't require high levels of specification and sort of unique approaches across the waivers that, in fact, impedes sort of simple tasks like providers being able to serve more than one or two waivers. And, so, we're really looking to address some of that complexity.

Recommendation number two is to implement5 a universal assessment tool. Today, there

are roughly three to four assessment tools used across the waivers to identify the needs functionally and in the community to support participants.

We are advocating for and recommending moving to a single tool that operates somewhat like a decision tree where you may have sections that are universally applicable but there may be subsets with sort of if-then scenarios that would lead you to further assessment that's tailored to individual populations so that we wouldn't have to lead everybody through this mammoth assessment that would take hours.

But we do think that that standard approach will really help to reinforce needs assessment and make sure that we're approaching all populations in a consistent, equitable manner.

Recommendation number three is to implement an individual budgeting methodology. We really see this as a framework to take the information that's captured in a needs assessment and translate that into a resource commitment for that participant to meet their care needs.

Today, the Cabinet leverages a retrospective system where they take the past use and utilization and draw conclusions and average that out

and then apply that standard to everybody. We are recommending an individualized approach, acknowledging that some participants have higher level-of-care needs. Some participants may have lower level-of-care needs and you need to be able to make best use of the limited resources available and really allocate them according to need.

Recommendation number four is to reinforce the rate-setting methodology. Again, that's the study that's been alluded to. The methodology in Kentucky for payment of home- and community-based service providers has really not been looked at in depth in a number of years.

CMS is really expecting that when we submit waiver renewals or waiver amendments, and, candidly, will expect that to be re-looked at every five years. So, certainly now is the time to look at the way that rates are established and make sure that that's done in a sound, transparent manner.

Recommendation number five applies to that living space. That, again, is where we operationally sort of live and breathe every day which is to standardize operating guides.

When we were in focus groups, one of the things that we heard often was the

frustration that, depending on who you called on what particular day related to these programs, you might get a different answer, you might get a different perception, they may handle it in a different way. That is not the ideal way to run the show, so to speak. And, so, we're really looking to standardize operations, acknowledging the likelihood that there will still be multiple agencies that participate in that administration.

Recommendations number six and seven apply to that wall concept or the wrap-around that really helps to support the participants and keep the system in full motion.

Recommendation number six is to strengthen case management services. I think that there are really two areas sort of subsequent to this recommendation. Number one is to offer a clear, transparent set of criteria or performance objectives that make it clear what case managers are responsible for and what their performance standards are.

I think that additionally, in order to support case managers in meeting those standards, we have to go back and look at where the State may need to create tools to support case managers in doing their work consistently across the

state.

Additionally, I think that it will be critical, as a case manager myself for many years, to really look at maximizing training and helping provide reality-based training based on the intensity of the participants being served and the challenges of being out there in the field. I think that's going to be really critical to moving the system forward.

MR. CARLE: Jason, I might suggest at 1.6 that you use the term you used. On here, it says establish and implement. That leads the reader believe that they were never in place. We know that some were in place. I would use the word strengthen as you did in your presentation as opposed to what's in here.

MR. GERLING: Great. Thank you for that feedback.

Recommendation number seven is to improve participant-directed services. There are a lot of participants on the waivers who select to self-direct their services for a number of reasons including a lack of available providers or just the desire to self-manage their care.

There is a lot of opportunity

to reinforce participant-directed services both from a regulation standpoint, making regulations clear and consistent and transparent so that participants understand the rules and understand the limitations of participant direction.

Beyond that, I think that we also are recommending reinforcing fiscal management agencies, those entities that process the payroll and have other administrative and financial responsibilities to help make sure that those participant-directed service workers employed by a participant are paid and are properly vetted from an employer's standpoint.

So, we're really looking to reinforce that system so that it is more user friendly both for the FMA's but also for the participants.

Recommendation number eight applies to the roof or that oversight monitoring which again is so critical to make sure that all parts of the system are operating as they should.

We are recommending that the Cabinet centralize quality management and oversight into one single team housed in the Department for Medicaid Services so that there is one single,

uniform approach that consistently applies to all services and all waivers and how quality and compliance is monitored and overseen.

Today, there are three different agencies that have three different approaches that they apply to different waivers. I think that we appreciate that everybody is well-intentioned and committed to oversight and monitoring, but certainly it is difficult for providers to interact with three different agencies who may be doing three separate audits through the course of a year.

It's not a practical way to go about that and certainly doesn't fully reinforce a consistent approach to monitor and oversight of these very important services and very vulnerable participants.

Recommendation number nine relates to the front yard concept or really opening up the Cabinet doors to let stakeholders in and allow them to meaningful engage in program design and program input.

So, this isn't just saving face and saying we're going to sit down with you and have a nice, pleasant conversation and give you water and

maybe a cup of coffee and then send you on the way. The goal is really let's bring people into the fold who live and breathe and rely on these services on a daily basis and engage them in a meaningful way, take their feedback and apply it to our decision-making.

We are recommending that the Cabinet do this on an ongoing formal basis and that they loop a number of entities into this, including the MAC, its Technical Advisory Committees and to better engage with some of the participant-driven boards that exist throughout the state so that we can really optimize stakeholder engagement and better reinforce a commitment that participants, providers, advocates and other stakeholders have a seat at the table and that their voice matters.

Recommendations number ten and eleven refer to future plans. So, much like all of us who have homes are looking down the pipe at what we might need to fix or remodel, we have to do that with the waivers as well.

So, one of our future plans is recommendation number ten which is to implement a quality improvement strategy. The approach in the Cabinet today has been very compliance driven. It is very much about the rules and the regulations. It's

probably overly focused on paperwork and under-focused on performance.

We are recommending moving away from that approach and starting to meaningfully look at quality so that the Cabinet can start to put initiatives in place within a number that's manageable by providers that move the system forward and advance outcomes, not just focus on meeting the minimum criteria.

Quality improvement strategies are also expected from CMS and it is something that we're really going to need to build from the bottom up here in Kentucky should the Cabinet choose to go forward with this recommendation.

Number eleven, our recommendation is to assess the mix of waivers after implementing recommendations one through ten.

So, our recommendation is based on the conclusion that we've drawn following this first year of assessment, that it would be unsound of us to recommend that the Cabinet move full steam ahead with a reconfiguration of waivers until they stabilize their current waivers.

We're concerned that if we were to look at the limited data that's available now,

that that data would reflect a system that is performing with some basic impediments that could be resolved before we move forward with that analysis, acknowledging that this population is a high-impact, highly vulnerable group, and I think any changes that we make that are as sweeping as reconfiguring waivers need to be made in a really methodological way that's well-informed and reflects the best interest of the participants.

So, we often say in this recommendation, the goal is not to change for change sake. It's really to advance these programs with the end user, the participant, in mind.

MR. CARLE: So, Jason, along those lines, so, you've leaned this thing out, okay. Where are your performance indicators? You just mentioned performance but what kind of key performance indicators are you going to set in place to know that you've actually accomplished the work that you set out to do? So, where are the metrics related to success?

MR. GERLING: So, that's actually kind of a challenge in home- and community-based services and I think it's an interesting question insofar as it's sort of the final frontier

of healthcare where quality standards and performance objectives have not been well-applied in a lot of states until managed care came into the fold.

And I say that not to say we're moving to managed care here. We're doing all of this within a fee-for-service. I think where we can start with performance objectives and we're starting to implement this within the course of the waiver redesign is to look at performance objectives, basic things like maximum numbers of days to get a test completed, maximum numbers of days to complete a cycle log making an approval or issuing a determination, maximum number of days of resolving an appeal.

So, that's really some of the types of objectives that we are looking to move toward. We're also looking to do that from a contractor vantage point where, as we look at some of the third parties that engage in the system and help to provide this oversight and monitoring and administration, making sure that there are clear benchmarks and that everybody knows what their objectives are. Does that help?

MR. CARLE: Yes.

MR. WHITEMAN: And just to add

a little bit more to that as well, within the waivers themselves, CMS requires what are called waiver assurance measures and CMS defines the buckets of those measures.

They allow states flexibility within those buckets of measures to design their own measures, and within that, there are a set of measures called administrative authority measures and that's really where I think we can tweak and really examine the measures that are currently in place to look at, from an administrative authority position, are we really capturing the data that we need to be able to understand if we're meeting the objectives that were stated.

MR. CARLE: Thank you.

MR. SCHULT: To piggyback on Chris' question a bit, one of the things you mentioned was waiting lists and I noticed that in the Goals section, there's nothing addressing waiting lists, eliminating them, reducing them.

Do we have data on what those are, what our goals are? That seems like a very good numbers-oriented one.

MS. HUNTER: Absolutely. Thank you for the question. We are aware of our numbers on

our waiting list, and, again, we are in a very, very tight budget time. So, I don't have the luxury right now to say I have lots of extra slots, that they've all been funded. Our budget is public record on how many additional slots have been funded and in which year and it's the second year of the budget that there were some slots made available in some of the waivers.

So, the challenge is is we have many individuals waiting and slots that we are continually trying to fill. And as you know with the Michelle P. waiver, we've been working diligently to get those numbers managed because there are individuals waiting on the Michelle P. waiver that will never qualify and that's just been a decision made historically that we inherited in our managing.

So, the best thing we can do with regard to slots is be aware of what the process is, who is waiting and how we can efficiently and completely move through our evaluation, the clinician's evaluation, not mine, the clinician's evaluation and appropriate appeals because every evaluation is granted an appeal should it be denied.

So, we need to continue to move, continue to be aware of our lists and continue

to beg for money.

MR. GERLING: I can offer a little bit more insight there.

MS. HUNTER: Please do.

MR. GERLING: One of the recommendations that we intend to present during the more robust recommendations we release in the summer is related to offering a better pre-screen for wait list entry.

So, one of the challenges today is there really is no data available on particularly the Michelle P. waiver wait list for us to analyze. So, essentially you have thousands of people out there for whom there really is no active knowledge of whether they truly are eligible for the waiver or not.

We are seeing a lot of states on the Navigant side getting lawsuits because of having wait lists that are based on chronology or that first-come, first-served approach.

So, it's certainly going to be a recommendation of ours that as a part of the admission process, and probably we'll dovetail it to the universal assessment tool recommendation, is to really look at a wait list pre-screen strategy to

help inform folks who are seeking services about whether or not they're truly eligible, keeping in mind that if you're somebody that seeks a wait list slot and then sits on that wait list for multiple years and all that time you were ineligible, it's kind of like thinking that you have a ticket that you really don't have. And, so, we really are looking to remedy that.

MR. SCHULT: And that's exactly what I'm asking about. I understand the slots. There's limited.

The second question unrelated, this recommendation number two, when you say a universal assessment tool completed by an independent entity, who are you envisioning as that independent entity?

MR. GERLING: So, I can't speak on who the Cabinet is envisioning. I will say that as an independent entity goes, what we have discussed and the reason that we used that language is that there is real concern that the current assessors, particularly case managers, write to their audience, so to speak.

So, they put information in the assessments that allows the person to be deemed

eligible whether that assessment is accurate or not.

So, for the time being, in a state where the Medicaid agency is not confident that that is not a widespread issue, we are recommending using an independent entity that is not connected to any provider of any home- and community-based services.

MR. SCHULT: Right. That makes perfect sense, but in Kentucky, do we have an idea of who that would be? I would assume different groups in different parts of the state or are we still trying to figure out who that would be?

MS. HUNTER: At this time, the Navigant steps and their recommendations have not been fully vetted with all the stakeholder groups and then a decision made with the stakeholder input on which ones we're going to use.

So, should we take that one as one of ours, this entity, our team, our recipients, should that be a decision that that's one that we accept, it will have to do one of two things.

It will either be made available to us in an appropriate fashion that CMS approves or procured and it will all stem with what CMS expects of us. Is that something we have to

procure through Model Procurement, and should we have to do that, we, of course, will or is there another method to that?

MR. SCHULT: Okay. Thank you.

MS. HUNTER: Absolutely. So, let me----

MS. STEWART: I have a question. Is the wait list due to on the Medicaid side or lack of providers?

MS. HUNTER: The wait list is complicated in that there are many people again - and I know I repeat this every time - but with all due respect, we have people waiting that will never qualify.

So, if we're speaking just about the Michelle P.-----

MS. STEWART: I was not specifically Michelle P., just across all waivers.

MS. HUNTER: Wait lists are based on available slots approved and funded. It all comes down to space. And with slots, again, it's a very finite process. We have to have individuals assessed. If they do not qualify, meet qualifications, then, they have appeal rights. So, that is a very slow and methodical process. It's

very time intensive to get someone who will never qualify to move on so that we can look at the next individual.

MS. STEWART: Do you have participants who have qualified that you have no providers for?

MS. HUNTER: Providers I don't know are as much of a variable. More providers are always wonderful. Kentucky is always looking for more individuals. I don't know that it's a provider variable. Maybe if we consider case managers a provider, we have some case managers that are alleging they are overburdened. They have too many people that they're serving.

We could always use more providers but I don't know that that's the only variable complicating the issue.

The issue, I hate to say it because I can see my finance guy out of the corner of my eyes as I sit here and speak to you all, it always goes back to money. I'm looking for unlimited funds and they don't exist and we're in a tough budget time.

MS. STEWART: And the same thing with providers. On the home- and community-

based program, providers have chosen not to provide that service. So, I guess my question is more related to that. Are the open slots in that program related to lack of providers?

MS. HUNTER: I don't know that I could speak to that eloquently. So, I will take that back, if that's acceptable, as a takeaway to make sure I address that thoroughly for the next TAC. I'll owe you that answer. If you will present it through as a question, I'll owe that as the next answer.

So, does the home- and community-based waiver waiting list, is the waiting list, in part, due to lack of providers, right?

MS. STEWART: Correct.

MS. HUNTER: Okay. Next steps and we'll wrap up. So, what are the next steps? Where are we headed?

The Cabinet again has conducted - and this is Slide 17, you will see three stars - the Cabinet has conducted statewide town halls and we allowed during those town halls stakeholder testimony.

It was a wonderful, wonderful experience. I want you to please be assured that

folks have something to say and they came to talk to us and it was the best experience I've had in my job in a very long time listening to moms and dads and grandmothers, grandfathers and recipients speak very much from the heart of the need.

Another important next step is stakeholder feedback will be compiled and reviewed. So, we are taking every venue of stakeholder feedback be it testimony, be it an email, be it a sidebar when they pull me to the side and ask a question, I jot it down, every type of response, communication and testimony from our recipients and our stakeholders.

So, providers, caregivers, recipients, we are taking all of that into consideration as we look at these steps that Navigant has offered to us for consideration.

And, then, finally, there will be a report with recommendations and anticipated implementation strategies with the draft waivers. And, again, those draft waivers are only being made consistent at this time, definitions, things of that nature.

They are not being changed at this time and that's important. You're going to get that question as serving on our MAC. What are they

doing to my waivers? So, please assure them at this time, as my grandmother would say, clean up your own back porch first, and we are cleaning up our own back porch first. That was an important thing we needed to do in our agency.

I believe the Commissioner said at one point it's a heck of a way to run a railroad. So, it gave us an opportunity to clean up our own back porch first before we try to impact others right, wrong or otherwise.

So, the timeline. We've completed, again, as Jason shared, this Tuesday our last town hall. It ended up here in Frankfort.

Phase One, this will be our implementation activities that we've just shared with you now. So, Phase One will continue through December of 2019, not even looking at a Phase Two as Randy referenced until 2020.

So, we're going slow. We're taking our time. I know I came to you probably more than once in apology and said I short-sided it. I thought I could do it quicker. I was wrong and I will always tell you if I'm wrong. I was wrong.

Let's take our time. Let's do it right, with the support of keeping you all in the

loop, as I've assured Dr. Partin that we will continue to do, and we'll be here until you're tired of hearing from us. I'm passionate about this group. So, your interest is appreciated and your support; and if anyone has any more questions. If not, we'll let the boss come back up and continue.

MR. SCHULT: Just one more thing. I know this is very early on in the process. I look forward to future presentations.

Two things, piggybacking what Chris said. We love metrics, numbers, metrics.

MS. HUNTER: Absolutely.

MR. SCHULT: And, second of all, this is not a criticism given how early you are, but a lot of these recommendations probably could be applied to all fifty states. And I look forward to seeing the Kentucky-specific ways we're going to make changes, but thank you for your time.

MS. HUNTER: Thank you very much. Thank you all for allowing us to present.

COMMISSIONER MILLER: Good morning again. Steve Miller, Medicaid Commissioner.

I had been sent a number of questions or topics to chat a few minutes about, but already we've heard, as we've gone through and talked

about the 1915(c) redesign, conversation about slots, availability of slots, the funding of slots, and I think it would be an understatement to say in this past budget session, there was a lot of attention to just that - the budget - and how tight the budget is.

There was a lot of discussion as it related around pension, education and, then, tax revenue to help fund some of the shortfalls.

What you didn't hear was a lot of conversation around the Medicaid budget itself. Good, bad or indifferent, that wasn't at the forefront this time; but what I can say to you is that the Medicaid budget over the next two years, especially the second year, is extremely tight.

You can use whatever adjectives you want, but it will be a very tight budget which puts any sort of expansion into new services, different things that we do, enhancement of those services very questionable.

When one looks at the Medicaid budget, it seems and looks like big numbers, but part of that is the additional state funds that it takes to fund the Medicaid expansion population.

Now, for us to continue to do exactly what we are doing today over the next two

years, and two years will start July 1, requires an additional $250 million of state funds and we've done nothing but effectively just keep the doors open doing exactly what we're doing today.

The Medicaid budget covers that but doesn't cover a whole lot more. Again, I've emphasized the second year of the budget will be extremely tight. We are still working through those details, some of the legislation that was passed.

We will be making an official kind of budget presentation to the Medicaid Oversight which will be at the end of June, somewhere around June 23rd or 24th, whatever that date is.

That is when we will have our presentation put together, some of our thoughts, our concerns and start laying it out to the Legislature as to our concerns for the upcoming budget.

DR. PARTIN: Excuse me, Commissioner. I'm having a little trouble hearing you. Could you speak up just a little bit? I'm sorry.

COMMISSIONER MILLER: We'll try to do better with that.

DR. PARTIN: Thank you.

COMMISSIONER MILLER: In

addition, the question has been asked as it relates to the MCO RFP. Now, we will be entering into new contracts or at least renewal of contracts with the MCOs effective July 1, '18, a month and a half from now.

As part of that process, we go through and adjust our rates. We can go through and revise the contract itself.

We at one time had said that we were going to make that a six-month contract, with new contracts, a whole new format starting 1/1 of '19.

We decided that was not the wise thing to do. In fact, it was inconsistent with where we had been initially, and that is, as we were bringing up the 1115, we felt like we needed a minimum of one year of just letting some of the dust settle with the existing MCO participants, the MCO partners in implementation of the 1115.

As that approval from CMS drug on and as I've said here before, it really didn't drag on that much more than what we see in other states in 1115. The challenge was we had a change in administrations which gave a lot of down time in that process.

Come the end of the day, what that all means is that we will sign, we will implement contracts for one year starting July 1 of '18.

It's anticipated right now that we would put out RFP for the period that starts after that with that RFP going out sometime late fall, somewhere around the first of the year, but I would add all that is still subject to all the implementation and as the 1115 comes on board as well and that evaluation.

MS. CURRANS: Can I ask a question about the contracts that will be out in June, in July?

COMMISSIONER MILLER: Yes.

MS. CURRANS: In House Bill 69, that's the one that addressed the auto assignment.

COMMISSIONER MILLER: Yes.

MS. CURRANS: And it also addressed the utilization criteria.

COMMISSIONER MILLER: And uniform credentialing.

MS. CURRANS: Right, but more specifically probably the priority that we see for a lot of young mothers that had babies, this auto-

assignment issue, are those issues going to be addressed in the 7/1 contract, the auto assignment and their requirement for, well, they won't even know yet because the DOI probably hasn't even started addressing how they're going to make that decision on utilization criteria.

COMMISSIONER MILLER: There will be some comments on that that we're trying to nudge in the contract itself, but keep in mind, we're still operating under the old format. We are preparing ourselves to make that transition, especially on the credentialing side itself.

By legislation, we have to have the credentialing, which I think those of us in the field have longed for for a number of years, to have that on board for contracts after 7/1 of '18 which puts it back in that time frame of 7/1 of '19.

MS. CURRANS: The auto assignment, Commissioner Miller, is very frustrating to the participants in the Medicaid Program because moms maybe got Passport and they just auto assign them to Humana and pediatricians in that vicinity don't take Humana, as an example.

COMMISSIONER MILLER: To address that a little bit more thoroughly, we are

going to emphasize with the beneficiaries that it is their decision to make and try to encourage them to make that decision.

MS. CURRANS: Good luck. We've tried that.

COMMISSIONER MILLER: And that becomes the issue at that point. If they haven't made the decision, then, we've got to do an auto assign for them. You're right, it is challenging at best.

MS. CURRANS: But couldn't they at least look at if even that MCO is in that region before they make that auto assignment?

COMMISSIONER MILLER: What takes place and from where I have sat before, all MCOs are in every region and there may be some MCOs that may not participate with hospital providers in that region but they are with all others.

So, what we have found is that in some cases, we have the beneficiaries who will stay with the panel of an MCO that may not have a contract, in your case, with the hospital.

MS. CURRANS: Right, with specific doctors.

COMMISSIONER MILLER: And that

is mandated by CMS that that individual have that choice.

MS. CURRANS: Do you want to wait on the appropriateness criteria until you're through talking about contracts? I have another question about the Milliman and the InterQual, how you think the process will happen with DOI.

COMMISSIONER MILLER: Obviously we're waiting for that to evolve. We had, we being the Department, had attempted to narrow down to one set of criteria.

I have said a number of times that I felt like what we tried to do was the right thing to do. Someone came back and told me effectively it wasn't the legal thing to do. Okay.

I have said from the get-go that I didn't necessarily have a preference of one of the sets of criteria. There are primarily two that are nationally known. I did not have a preference other than I wanted it to be----

MS. CURRANS: Consistent.

COMMISSIONER MILLER: ----one, one. I really didn't care which one.

We'll see how that evolves with DOI and some of the input there.

MS. CURRANS: Because I think we're up to four out of the five now use InterQual. So, it seems like such a simple just little finish to get it done, but I knew it was House Bill 69 and I just wondered how it was going to be playing out.

COMMISSIONER MILLER: Just as you say a simple thing to do, we thought it might be. We attempted and it didn't quite work. So, that's why you had to go through a different process. That didn't give you a good answer other than it's the process that we have gone through.

And as we've talked about as far as House Bill 69, as part of the delay process and looking at the RFP, there were a number of items that were very much in play during this last Session, whether or not it's SB 5, SB 53, and all those impacted directly the structure of our MCO contracts which just made it almost impossible to try to develop an RFP at that same time.

That was part of that input, but as much as anything, it is the time that will be needed for the 1115 to let that dust kind of settle, as well as the fact, and Deputy Secretary Putnam will go over this when she arrives but how we are stair-stepping that implementation during the fall.

MS. CURRANS: I don't want to scare you but she has arrived and is right behind you.

COMMISSIONER MILLER: I didn't flinch. I wasn't aware of that yet. Thank you.

So, those were basically the prepared comments I wanted to make this morning. It is always open and I'll field any questions.

DR. PARTIN: When you were speaking about the budget, I just want to make clear in my own mind if I understood you correctly. You said that there isn't enough money to continue the services as they are now. Is that right?

COMMISSIONER MILLER: There is enough money to continue the services as there is now. The second year, that gets real difficult because we always have increasing costs. The budget the second year, it will be extremely tight, and I keep using that word. We are assessing just how tight that will be.

Now, what comes down come the end of the day, anytime you look as it relates to Medicaid the $30 million a day that we spend, the almost $7 million a day in state funds, if you're going to have any sort of meaningful either cost

savings or to help balance that, it's three-legged stool. When you look at the number of enrollees, today we've got 1.4 million across the state, a third of the state's population, if you look at the services that we are providing there through basically our five MCOs, or you come up with an additional revenue stream.

It's not articulated out yet but we will be laying that out to the Medicaid Oversight Committee at the end of June as well and then see what answers and what guidance and what alternatives they see for us.

Budget the second year, state fiscal year '20 is going to be a real challenge.

DR. PARTIN: So, it's possible that we might see cuts in services?

COMMISSIONER MILLER: Is that possible? I would say, yes, that's a possibility. That's not one we want to put on the top of the list, though. We think we have other options there.

MS. CURRANS: This budget that you're speaking of, does it include the Rewards Program? Will it have been implemented for the most part fully?

COMMISSIONER MILLER: I mean,

that will be part of the 1115, but, Ms. Currans, as it relates to a budget component, it is----

MS. CURRANS: It's minimal.

COMMISSIONER MILLER: Well, as somebody would use the term decimal dust. I mean, you won't notice it.

MS. CURRANS: Right, right. It's just when you start talking about potentially cutting services, the whole package is just scary to providers moving forward, quite honestly, because we all hear that same story, that there's going to be less money. Well, less money usually means less available service.

COMMISSIONER MILLER: Or some reduction in fee schedules to do that. None of that is good.

MS. CURRANS: No, because providers are still an issue and less fee will certainly create less providers, I'm afraid.

COMMISSIONER MILLER: I understand that.

Being that she snuck in behind me unbeknownst to me at the time, I will now turn this over to Deputy Secretary Kristi Putnam to talk about the 1115.

DR. PARTIN: Commissioner, we had that other question about the feedback from the MCOs regarding requests for patient records for monitoring quality measures.

COMMISSIONER MILLER: Sorry. We've gotten very little feedback to that to date. Now, we had reached out and asked for providers to send us information, send us examples of that. And other than what we heard here kind of anecdotally, we've not gotten anything back from providers.

We will continue, as we do all the time, monitor the activities with the MCOs, but as it relates to additional feedback, the honest answer to that is we've had none.

DR. PARTIN: Could you query the MCOs and ask them what they're requesting from the providers?

COMMISSIONER MILLER: We will do that. We can do that and we'll report back at the next MAC.

DR. PARTIN: Thank you.

COMMISSIONER MILLER: Again, thank you.

DR. GUPTA: Commissioner Miller, I have a question.

COMMISSIONER MILLER: I'm not in a hurray.

DR. GUPTA: Just to play the devil's advocate a little bit, if the My Rewards Program is not going to relieve any significant amount of the budget, I was wondering what was the primary purpose other than getting--I believe in the My Rewards Program and I like what it is going to be doing hopefully, but from a financial standpoint, what was the primary goal of implementing the My Rewards Program?

COMMISSIONER MILLER: If that was a takeaway from the way I walked through that, let me back up.

I took it that as far as the My Rewards itself, whether or not that was going to be an expense to the state, and I would say that's minimal.

From the standpoint of using that as part of the incentive to help bring about compliance, to help get individuals involved in the 1115 and take responsibility, that is a major driver in that, trying to get individuals involved in their health care, but the cost itself of the My Rewards is minimal.

DR. GUPTA: But do you feel that the My Rewards Program will help alleviate some of the burden of the budget?

COMMISSIONER MILLER: I believe the entire component of the 1115, which My Rewards is a significant strategy there, that the 1115, given time to come on board, will have a significant impact to the state. That's a few years off, but in the long haul, yes.

That is the whole reason for the 1115 demonstration to show where we can bring about better results and hopefully a reduction in costs but better results at worst that cost us no more to do. And if you get better results and you get people off the Medicaid rolls, we have a positive there.

DR. GUPTA: Thank you very much.

MS. ROARK: Commissioner, my son got a letter saying people is going to be paying $15. I guess not the medically frail. Is that how they're going to try to get money back into Medicaid to pay for this?

COMMISSIONER MILLER: As part of the incentive and having individuals now being

somewhat more involved in their health care, there will be premiums varying from $1 to $15 per household, depending on where they are in classification, as well as income levels.

Again, that revenue stream, sort of speak, will be minimum, but what it does is a very good pattern. It is basically trying to give the input, the teaching skills as it relates to trying to get individuals more adapted and used to commercial insurance where there is a premium and where they also, then, have to make choices as to how they go out and obtain services.

Any component within the 1115 is just that. It's a component, but you've got to look at the 1115 in its totality and that is just one of the components there.

MS. ROARK: And what do you mean by classifications, like, for example?

COMMISSIONER MILLER: Looking at the different eligibility, who they are, where they are as far as income levels and that classification.

MS. ROARK: Or would be it with their health?

COMMISSIONER MILLER: If it's

100% of poverty versus 138% of poverty and stair-stepping in between.

MS. ROARK: And also they sent a survey out to my son. If he filled it out, they're going to give him $25. Are you aware of that?

COMMISSIONER MILLER: There may be other people in my shop that are directly aware of that. The honest answer is, no, I'm not.

MS. HUNTER: It's probably a health survey from one of the managed care organizations. It's an incentive so that they can learn more about him to be able to better serve him. If the MCOs don't know about those individuals they're responsible for, they can't wrap around them and provide complete health services.

We do it through our insurance. Everyone that has insurance th rough an employer, you're going to be asked everything about your life so that your insurance company can better serve you and meet your needs.

MS. ROARK: And how do you reach out to people that have disabilities that maybe can't comprehend some of these letters that you've sent out, that can't read or write? How are you going to reach that population?

COMMISSIONER MILLER: We do that every day. That doesn't change with the 1115. We have that responsibility today. We do that through a number of different efforts, whether or not that's through mailings, whether or not that's through individuals that are pinpointed through providers to help reach out to those different groups, but the 1115 doesn't change that challenge.

MS. ROARK: And then they go to the doctors and they think they have Medicaid or MCO coverage and they get to the doctor and they find out they didn't pay maybe the $15. Are they kicked off Medicaid?

COMMISSIONER MILLER: We'll go through that later, but there is at least a ninety-day transition period there. So, it's not like all of a sudden, it happens. There will be a number of pieces of communication in between that.

MS. HUNTER: And to supplement that, this is a program designed with many on-ramps. It's not about just off-ramps. There are many on-ramps.

And I believe when our Deputy Secretary comes to the table to speak, she can speak more eloquently to the on-ramps, but when this

program was designed, those in leadership repeatedly reminded the team on-ramps. Should something happen, how do we explain to the individual how you can get back on safely. So, there are many, many on-ramps to this program.

MS. ROARK: And, then, there's a question for people with substance disorders. Are they still qualified to get Medicaid or are they going to have to work? They're going to have to volunteer to get these services.

COMMISSIONER MILLER: I'm sure we'll touch on that, but in many cases, they will meet the definition of medically frail as well. So, they will not have that kind of criteria to continue the coverage.

MS. HUNTER: And with substance use disorder, because it's not a permanent thing, an individual can move from the medically frail bucket out of it. So, should they go intensive outpatient and get in a mode where they're healing, then, they won't always be medically fragile, differing from someone with a primary diagnosis that's genetic in its background. So, wrapping around services, providing support and education, again.

Again, one of the positives

with the community engagement is individuals who are actively in treatment get to count community engagement hours for meetings. If they're in AA, they go to a meeting, that's an hour that counts.

So, we tried to wrap around the whole person versus just go work. It's go volunteer. Go to your AA meeting. How can we wrap around you to help you get a hand up versus making it punitive?

COMMISSIONER MILLER: I would say it's not just semantics, that it is community engagement. It's not just work requirements. Community engagement, be it work, be it education, be it volunteerism.

MS. ROARK: And underneath that, after you get that worked out, you've got to work on your mental health, for example, for my daughter.

MS. HUNTER: And we can talk afterwards. Is it a specific claim issue?

MS. ROARK: I'll speak to you after the meeting.

MS. HUNTER: Come see me and we'll talk about it.

MS. ROARK: Thank you.

COMMISSIONER MILLER: Any

additional questions?

DR. PARTIN: Thank you.

MS. PUTNAM: Good morning. I apologize for being a little bit late to the meeting.

I'm Kristi Putnam and I've been before you all numerous times at this point, and I would like to, Dr. Partin, if it's okay with you, give you just an update in general on where we are with the 1115 implementation and, then, there are a couple of questions I heard while Commissioner Miller was here at the table and Deputy Commissioner Hunter that are some details that I can elaborate on in response to those questions.

DR. RILEY: And can you move your mic a little bit closer?

MS. PUTNAM: I can and I'll also talk louder.

We are five weeks out from July 1st implementation to change over to benefits. That definitely is something that I wake up thinking about every morning and go to bed thinking about every night and maybe lose a little sleep over, making sure that we're getting the right information out.

We are holding regular stakeholder forums and those have been going fairly

well where we invite the general public, providers, MCOs representatives to come and meet with us.

As we walk through the details of implementation, the different pieces of Kentucky HEALTH, we have an opportunity for questions and answers, and we are taking a number of questions in and trying to provide those answers back out shortly after each of the stakeholder forums because they do generate new questions each time, as you can imagine.

One of the things that we have been engaged in in the past few weeks is we had from one of our vendors a team of individuals who went out and conducted some interviews to beneficiaries' homes. They went out and met with people through the assistors for the purpose of finding out just some information on are they getting information, is the information clear.

What we've learned from that is we still have work to do on making sure that we are being clear and concise with the information we are sending out and with how we are presenting information on what the new requirements are for Kentucky HEALTH.

So, we're working on improving that communication but also looking at some different

ways to do some outreach through digital media, social media because the letters that come in the mail, we know that the language in our notices of eligibility, while it's federally required, much of it can be very confusing.

One thing we just are sending out this week is called the Highlights' document, a highlights of your notice of eligibility that walks through and highlights very clearly the different sections of the notice of Eligibility that shows where the benefits are changing for those individuals who will be part of Kentucky HEALTH.

I heard your question about the survey that your son received. I believe that those surveys, it could have been an MCO. Deputy Commissioner Hunter is absolutely right.

But we also, as part of our evaluation plan with the University of Pennsylvania, are in contract with the National Opinion Research Center out of the University of Chicago to do qualitative surveys both before, during and throughout the five-year period of Kentucky HEALTH just to gather that information from individuals on their health care needs, their access to health care, barriers they are experiencing and just general

feedback about the quality of care they feel they are receiving to inform part of our evaluation design. So, that may be the survey as well. It could be that NORC survey.

I would like to speak to just the premium payment. The premium invoices have not gone out yet. The actual notice of eligibility for Kentucky HEALTH is scheduled to go out mid June. So, individuals will have that notice of eligibility.

At the same time, the MCOs will be sending out invoices to those households who will have a monthly premium under Kentucky HEALTH and those monthly premiums will either be $1, $4, $8 or $15 and that is for the entire household coverage.

And I'll pause there--well, the suspension for that. So, if there is a non-payment situation, again, to go back and answer that question, once an individual receives that first premium notice, there is a sixty-day period within which that person can make that first premium payment.

So, if I get my statement in July, I don't make my payment in July, I will get another statement in August that shows both my July and August payments are due. If I still don't make

that payment in September, the eligibility system will put on a pending suspension that shows it is pending. That person still has coverage through the month of September. So, it's actually more like a ninety-day period. The benefits do not get suspended until October 1st in that scenario that I just walked through.

So, there is an extended period of time. And once that payment is made, if they make t6he payment while they're still within that period before a suspension has actually happened, there will be no gap in coverage. They will continue to have Medicaid coverage.

MS. CURRANS: Can I ask you what that time frame is and where they might be allowed to go make those payments?

MS. PUTNAM: Yes. The time frame for making payments, they do have, from the initial premium notice, there is a sixty-day period.

MS. CURRANS: Right, but I'm saying let's say I haven't made it and now I'm about to lose coverage and I want to make it. Where can I go make it and how quickly will it resolve that near loss?

MS. PUTNAM: Sure. Of course,

how quickly it will resolve could depend on the manner of payment because if it's a cash or a check payment, that does take a little bit longer to credit than if it's an electronic online payment.

We have asked the MCOs, we've required the MCOs through their contracts to make available payment processes on their websites. They are also putting partnerships with vendors in place through, for example, Family Dollar stores, Kroger's, Walmarts at no cost to the beneficiary. They can go make a payment at some of those locations, depending on which MCO. The payment can be sent in, mailed in by check.

We also have been working very closely with the Kentucky Hospital Association and other providers who are interested in also having the ability to have a payment made onsite.

MS. CURRANS: And that's what I wondered. Physician offices and/or hospitals, can they be a payment site?

MS. PUTNAM: That is what we are looking into so that if there is a way, and the preference would be to have that as an online way to do that----

MS. CURRANS: Yes.

MS. PUTNAM: ----so that providers aren't in the situation where they're collecting checks and cash and that sort of thing. There's less liability that way.

We are looking at can we have that? Is there a possibility of having a computer available for individuals to make that payment.

So, the easy answer is yes because individuals can log on to their MCO website.

MS. CURRANS: Right. And most hospitals had folks to help people sign up a few years ago when they were actually going into the expansion program for the majority of those folks. And, so, they've already got a person and a computer.

MS. PUTNAM: Yes.

MS. CURRANS: I would think it would be pretty simple.

MS. PUTNAM: That is what they are considering is just taking that and being able to expand that role.

DR. PARTIN: Will the premium be waived for the medically frail?

MS. PUTNAM: Yes. There is no cost share for medically frail, for pregnant women, for children. There's no premium for those

individuals. Former foster youth are the other group who do not have a premium or a copay.

DR. PARTIN: So, some of the people, though, you may not know that they're medically frail yet. So, how does that work as far as them getting the notice for the premium and, then, them being designated as medically frail?

MS. PUTNAM: There is a possibility if someone has not yet been found medically frail through claims that they would get the invoice obviously because they're not designated but they believe themselves to be medically frail or their provider may.

And as they go through the provider attestation process, once they are determined medically frail, that designation goes back to the first of the month in which they were found to be in a medically frail status.

So, if there was a premium charged during that month and in that same month they're found to be a medically frail status, that premium would be waived. They would not have that premium payment.

If they do make a premium payment and later on the next month they're found

medically frail, the premiums stop at the point where they have been determined to be in a medically frail status.

DR. PARTIN: And, then, the forms that we got, they were just draft forms for the providers to complete for the medically frail. When will we have the forms officially so that we can fill those out? And can we fill those out before July 1st?

MS. PUTNAM: I believe the answer is yes to filling it out before July 1st. I have to phone a friend. The reinforcement is in the back.

Once that form is finalized, it will be available to be used. You don't have to wait until July 1st. Those can be completed and sent in.

The forms, we thought they were final and, then, there was a question about the medically frail determination or a couple of categories that we, the State, have had input from a number of our partners and community groups to make sure that we provide some protections for our refugee individuals and for individuals who are the victims of domestic and interpersonal violence.

We opted to include those as a

medically frail category. CMS has asked us to have a conversation with them about the right way to make sure that we don't create a new medically frail eligibility category and, instead, we do that through an operational mechanism in our system.

DR. PARTIN: So, are you going to be sending that final form to all providers or how will providers know?

MS. PUTNAM: We are going to be sending it to all providers. It will be available on MCO websites as well. Most of the MCOs are putting that as an online design so that it can be completed online. It will be available through the Medicaid website, all the MCO websites and on the Kentucky HEALTH website.

DR. PARTIN: So, will providers get a notice to go and look at the website?

MS. PUTNAM: We will send communication out that it's finalized and where it's available, yes, ma'am.

DR. PARTIN: And, then, I guess just along the same line as the notification for that, as a provider, I haven't gotten any information about what's going on and going out to the patients. And I think it would be really helpful for providers

to know when these notices are going out to the participants. Invariably, the participants are going to be asking us and we don't have a clue.

MS. PUTNAM: I know that we have been sharing those notifications with a number of groups. So, if you have not received any, we need to make sure that we have everyone on the list.

DR. PARTIN: I haven't received anything.

MS. HUGHES: Beth, I've been sending stuff out that's gone out to each of the MAC members. I've sent communication pieces that we've mailed out.

DR. PARTIN: That's going out to the participants?

MS. HUGHES: Anything that has gone out so far, yes, I have sent it to the MAC members when they go out.

DR. PARTIN: I didn't see that.

DR. RILEY: But not to the regular providers because I got a piece of mail by accident in my mailbox that was designated for a recipient. So, I laid eyes on one piece of information that went out but that was just an accident. Nothing came to my office that would have

informed me that the recipient was getting this information.

MS. HUGHES: Well, all the communication is also out on the Kentucky HEALTH website. It goes out there, too. So, that's another way to find it.

DR. PARTIN: I'm just saying we shouldn't have to hunt for it. And if you've sent it to me, I'm sorry, I missed it; but as far as providers in general, we shouldn't have to hunt for that information. We don't even know to hunt for it.

MS. PUTNAM: Right, I completely agree. It's not our intent to make you hunt for anything. We want to make sure you're getting the information, too.

I think the method we've been trying to use is to send it out through different associations who can then get it to their membership because if you're trying to get it to every single provider, we know we will miss someone ut if there is a better way that we can do that.

First of all, we can make sure we send the website that has the direct link to all notices that have gone out, that we continue to circulate that to a wider audience, but we will try

to widen that group of individuals to whom we are sending those notifications.

DR. PARTIN: Thank you.

MS. STAFFORD: I have a question about the premiums and that it applies to household. Is that what I understand?

MS. PUTNAM: It does.

MS. STAFFORD: What about somebody that lives within the household that is medically frail? Does that no premium apply to the whole household?

MS. PUTNAM: The no premium only applies to the medically frail member. So, if someone is medically frail, it will be indicated. And the MCOs have done this different ways, but the medically frail, it indicates no premium or no cost share for that individual on the invoice.

One thing I would like to clarify is the premium is per MCO. So, if there is a household where let's say Jill and I are in a household and she has one MCO and I have another, we would have a premium for each of the MCOs.

MS. CURRANS: That's where, back to Commissioner Miller, I was asking him about this auto assignment. It's becoming more and more

complicated because auto assignment is being done too often. We were talking about House Bill 69 which says that MCOs really have to have a new way to move forward through auto assignment, but we had heard that each MCO would have a bit of difference.

Well, if I'm the mom and my babe is a different, we're already getting questions about who am I paying? Am I paying both because if one premium covers my house, do I send half of it to Passport and half of it to Anthem? It's very complicated for some of these folks that are concerned.

Now, I couldn't remember. If I have a new baby, am I going to pay a premium?

MS. PUTNAM: For the?

MS. CURRANS: If I'm in Medicaid as a new mom and new babe, will I be paying a premium or are children exempt from premiums?

MS. PUTNAM: Children are exempt.

MS. CURRANS: And I had said that to one mom that had asked me. There's a lot of fear.

MR. CARLE: So, Kristi, if we could, though, based on that line of questions, not

to spend so much time on the premium, but it's really the main driver of who is going to be in and who is going to be out essentially.

The Hospital Association really appreciates your all's willingness to review the mountainous amount of questions that we had, but just so everybody in the audience understands is that each MCO has the ability to develop their own collection process. So, Passport might do it at their office and WellCare could do it via Kroger.

And, so, I think that's Sheila's point and you're dealing with an entire state; that I think that if there was some consistency related to that, and I know you're just rolling it out, if there was somehow some consistency related to that, that puts everybody on an even par.

And hospitals are willing to help with that because we're on the front line where those individuals will come in and say, oh, gosh, I forgot to pay my premium. Can I pay it now?

And, so, I know you're working through all that detail but it is a rather complicated issue.

MS. PUTNAM: It is. There is consistency in the number of ways we've required MCOs

to offer payment. So, they are all required to offer the same number and the same types of payment options.

The venues through whom they choose to work is the difference, but I think that if we are able to work something out where we have providers and hospitals as an option as well.

And, then, the other thing that goes along with that is we have hospitals and providers who have asked for the ability to have some insight into Health Net to see when they have someone in their office who is in danger of losing coverage because they haven't made a payment.

So, we're looking at that which is a very delicate balancing act. We want to provide information that's helpful. At the same time, we have to make sure that patient information is protected. So, we're looking at what is possible for us to do to help facilitate providers and hospitals being that partner with that payment process.

MR. CARLE: Okay. Thank you.

DR. PARTIN: So, just to clarify, children in the home are not going to be charged a premium but the parents will.

MS. PUTNAM: The parents could,

yes. The parents could have a premium payment.

MS. STAFFORD: I'd also like to just make a comment. In our rural area, a lot of these people use the libraries. And, so, it might be a great partnership with the libraries for those premiums because that's where they go for computer and those people are more than willing to help everybody that comes through the doors. So, just a recommendation.

MS. PUTNAM: They are, and we have begun working with the libraries to partner with them. They have been very willing and many of them want to receive some additional training on Kentucky HEALTH and the different opportunities they have to help serve with that.

MS. STEWART: I have a question. In the scenario that you illustrated with the July non-payment, the August non-payment, September borderline payment, when they go to make the payment, do they have to pay all months?

MS. PUTNAM: They do have to become current in order to keep out of that suspension status.

MR. CARLE: Another consideration, Kristi, and this might be out of

bounds but I'll mention it anyway along the lines of the library is the local cable providers. People seem to have the funds to pay for cable and they usually do it with cash. So, just a concept or an idea because it's prevalent throughout the state and they have a franchise.

MS. PUTNAM: That's a good thought as well.

If it's okay, I would like to just speak a little bit more to I think Commissioner Miller and Deputy Commissioner Hunter were answering questions about budget concerns and there were a lot of questions about the 1115 being part of the solution to address budget concerns.

I think there's a lot of potential with the 1115 to be that front-end prevention, first of all, so that cost of care hopefully goes down because we have more people accessing their preventive dental, vision and other preventive services.

But the other piece of that is the reason I was not here to start the meeting with you all today, I was at the Kentuckiana Works Board meeting and we are working very closely with all of our workforce boards but with a lot of community-

based organizations because we fully believe that making the investment on the front end and, then, really working with individuals who are able to and who really seek to move from one place where they are in their life to a different place, investing that time, money and energy on the front end we are anticipating will pay dividends and will help us offset some of the cost two and three years from now.

So, I think that if you haven't already seen, you will start to see a lot more work around and a lot more partnering with community-based organizations, a lot more employer engagement.

Employers are very interested in having a healthy and participating workforce and healthy and participating employees once they come on board. They haven't really realized the role that they can play in health care and in healthy outcomes for individuals but they're starting to.

So, I think the partnerships that a number of individuals on our team are working very hard at will help us with that cost down the road and with our healthy outcomes down the road.

MS. CURRANS: In your all's work with these - and I think that's a great idea - but in your work, are you targeting the smaller

businesses that quite honestly when the expansion came about advised their employees to go out and get signed into the expanded program? So, how will you transition those folks back into perhaps an employer-based plan?

MS. PUTNAM: Sure. So, that is part of the goal of the employer-sponsored insurance piece which will be phased in in 2019. It will not be mandatory immediately.

This year, it's optional and we already do have a premium assistance program but we expect that to grow. That was part of the reasoning behind making it mandatory, that and providing sometimes better and additional coverage under an employer-sponsored plan.

DR. PARTIN: I have another question but I didn't want to ask it until you were finished with whatever you're going to present.

MS. PUTNAM: That's a summarized update and hopefully addresses some of the questions that were asked before I joined the table.

DR. PARTIN: So, my question is about regulations. When will they be coming forward and are they going to be like an E reg coming out the same day?

MS. HUNTER: We have recently hired in our Department a new reg writer. We were very excited that he was able to come on board. Jonathan will be working closely with our team, with our 1115 team, also with Lee Guice, our Director of Policy and Operations, with Stephanie Bates, Cindy Arflack, myself, all the way up to the Deputy Secretary to ensure that the regulations completely and thoroughly are written to support the 1115.

Should they meet E reg criteria, so, anything that's an E regulation either has to be a directive that comes down from CMS or there are a couple of other criteria that make an E regulation very specific.

It is my understanding in speaking with Secretary Meier previously that if we can make them E regs, that we would have his support but we don't want to overuse that process, of course. We want to follow the rules.

So, we'll do everything possible; and if they do meet E reg criteria, we will certainly push them forward as such.

DR. PARTIN: So, maybe I guess is the answer?

MS. HUNTER: I would argue they

would, but not having them in front of me, I wouldn't want to say they all will, but I would argue many of them would. It's CMS. It's a CMS directive. It's a CMS program. Many of the variables are at play; but as soon as I say it, I will be wrong. So, I'll tell you we'll do everything to ensure that they are.

DR. PARTIN: Okay. Thank you.

MR. CARLE: I might be asking an uncomfortable question but I'm going to do it anyway.

In the event that you all as the implementation team do not feel comfortable moving forward with this in five weeks, are you having undue pressure to actually meet that date, come hell or high water?

MS. PUTNAM: Absolutely not.

MS. HUNTER: Absolutely not.

MR. CARLE: Okay, because we've been here before with expansion. It took Medicare three years to install some of this and we did it in less than, what, six months.

So, I just want to make sure that you're not getting that pressure if you don't feel comfortable doing it and, then, you need to do the right thing and reset and set another start date.

MS. PUTNAM: Right. We agree with that. That's not an uncomfortable question. That's a fair question.

One of the things that we are looking at right now is we are establishing certain thresholds for even if and when we do start July 1st, in those first few weeks, months, if we meet certain thresholds to where we see a certain number of premiums that are going unpaid, we have the ability to change the system, hold the system, hold any suspensions, hold any penalties. So, we are looking at contingency plans for each circumstance.

MR. CARLE: That was my next question. Thank you.

MS. CURRANS: Mine, too, because before I think you got here, we talked about metrics. I can't think of a more important program that you all already should hopefully have some very well-defined, very clear outcome measurements in place so that you can pull the plug if you have to in thirty days or forty-five. So, you all do have some kind of critical measures in place?

MS. PUTNAM: We do. We are adding to them. We have the baseline but we are adding to those. I believe it's something we can

share with this group; and if it is, we'll absolutely get that to you so you can take a look at the metrics we'll be looking at.

July 1st is a self-made date. It is something that I have said publicly and I've said to many groups at many times that if we do not feel comfortable, this is too important that we don't--we have to get it right rather than get it faster on time, and if it's self-defined, it's also self-defined that we can change it to make it a different date.

MR. CARLE: Thank you.

DR. PARTIN: Any other questions? Thank you very much.

MS. PUTNAM: Thank you.

DR. PARTIN: Next we've got the recommendations and reports from the TACs. We've got some items to cover besides the reports from the TACs. So, I would ask that the TAC reports be as brief as possible, just give us your recommendations so that we can move on and finish up the other items that we have on our agenda.

And first up is Behavioral Health.

MS. HUGHES: She didn't have

any recommendations, did you?

MS. SCHUSTER: No. I have no recommendations but I'll have to make a couple of comments.

We continue at the Behavioral Health TAC, as Dr. Liu knows, to be concerned about the medically frail category, and I was glad to get the clarification that we will be getting those forms.

We again are, and you kind of brought this up, Dr. Partin, we're afraid about people falling through the cracks. And, so, at the March meeting, actually there was a suggestion made to Dr. Liu that there be some kind of grace period for this period of attestation.

The MCOs have maybe thirty days, could be as much as sixty days to review that material and then get it to DMS with their recommendation and, then, DMS has to make that eligibility determination and, then, it has to be communicated back to the person, and we're very worried about people who are not getting services are being required to pay premiums or have that work or community involvement during that period.

So, it just seems to me that we

really want to protect those people from falling through the cracks and, so, that grace period.

The stakeholder and provider forums that Medicaid has been providing I think have been very useful. The stakeholder forums have been even increasingly useful with the ability of people that call in to be able to ask questions and so forth. So, we appreciate that very much.

Chris, you mentioned that hospitals wanted to be helpful in collecting premiums or keeping people enrolled.

And I've made this statement before but certainly the community mental health centers have a vested interest, again, and they're a statewide network and if there's anything that we can do. If the hospitals are given some opportunity to help with on-the-spot verification or enrollment or collecting premiums or something, we would like to see the CMHC's also have that opportunity.

I think this is the first time we've not had any specific recommendations. So, I have a very short report.

DR. PARTIN: Thank you. Children's Health. Consumer Rights and Client Needs.

MS. BEAUREGARD: Good

afternoon. My name is Emily Beauregard. I'm the Executive Director of Kentucky Voices for Health and happy to be here representing the new Technical Advisory Committee, or I should say the revived Technical Advisory Committee on Consumer Rights and Client Needs as the Chair.

We met for the first time, at least in anyone's memory. We know that this TAC has been in statute for a long time but has not been active. So, we were very happy to bring it together with our first meeting on May 16th and we have four TAC members.

I know you want it to be brief but I wanted to just present their names since this is a new TAC. We have myself with Kentucky Voices for Health. Miranda Brown is the Vice-Chair with Kentucky Equal Justice Center. Miranda is an outreach worker and an application assistor. And we also have Arthur Campbell and Donna Littrell who both have personal experience with 1915(c) waivers. So, I'm very happy to be working with these individuals to represent consumers.

And I also wanted to very quickly thank some folks that helped us to get this TAC restarted. Dr. Sheila Schuster for one, Senator

Kerr, Eric Clark from the Cabinet and also Bill Schult. So, thank you very much for your help in getting this going.

And our recommendations from the first meeting were voted on unanimously and they include these seven. We recommend that the Consumer TAC be able to recommend consumers to DMS to participate in testing the availability and usability of the proposed eligibility system, Benefind, and Citizen Connect Portal system in the 1115 waiver. So, that would be user testing.

We recommend that alternative forms of access to the eligibility application and the Citizen Connect portal information be made available in paper format to Medicaid members with in-person assistance offered to them in order to assure that there is good accessibility for folks, especially those who need additional assistance with using a computer or other types of technology and provide them assistance to enroll and to make sure of the various accounts, the various components of the Citizen Connect portal and the different reporting requirements that are going to be part of that.

We recommend that following the example of being implemented for the 1915(c) waiver

redesign that we heard a lot about earlier today, we recommend there be a stakeholder advisory council for the 1115 waiver and that at least 60% of the members of the advisory council be Medicaid recipients.

In order to assure that no one who may be eligible for the medically frail designation is adversely affected during the application or attestation process, we recommend that the period of time between the initial application and attestation and the final determination of eligibility, that there be a grace period implemented so that during that time, there would be no requirement enforced of penalty enforced on the individual while they're waiting to be determined medically frail.

We recommend that the current arbitrary cap on the hourly rate that can be paid for participant-directive services in the Home- and Community-Based Services' waiver be removed so that individuals can pay the rate necessary to hire qualified service givers.

We recommend that adequate funding be secured to fill all needed 1915(c) waiver slots to address the waiting list backlog which we understand is over eight thousand people at this

time.

And, lastly, we recommend that a new 1915 waiver be initiated for Medicaid recipients with a severe and persistent mental illness in order to provide access to services such as supported housing, supported employment which are currently not covered by Medicaid Services for this population.

And just one note, that in voting on these recommendations, Miranda Brown who, again, is representing the Kentucky Equal Justice Center, wanted me to share a statement that she made which is that KEJC believes Kentucky's 1115 waiver to be unlawful and my votes on recommendations are regarding implementation steps if they are taken but that my votes do not endorse the 1115 waiver plan.

I would say that in general, none of our members are endorsing a particular Medicaid program when making recommendations. We're simply recommending that we increase access, expand services, improve quality, develop more patient-centered care and improve customer service. Thank you very much.

DR. PARTIN: Thank you.

MS. HUGHES: Emily, could you

email those recommendations to me?

MS. BEAUREGARD: Yes.

MS. HUGHES: Thank you.

DR. PARTIN: Dental.

DR. RILEY: Usually Dental is short and sweet but today not so much.

The Dental TAC is concerned that dental patients who are subject to the My Rewards Program will experience dental emergencies and not have enough money in their My Rewards' accounts for the needed treatment.

Without sufficient funds in their accounts, they will resort to seeking relief at hospital emergency departments costing many times the amount that the dental treatment would cost.

The TAC, therefore, recommends that all codes associated with dental trauma and infection be excluded from the My Rewards Program.

I won't go through the actual code numbers but the codes address the emergency exam, x-rays to diagnose the problem and extraction codes.

When the managed care program was established throughout the state, prior to that, oral surgeons had been billing for medically-related

services to let's say the MCO. However, the dental codes were covered under the subcontractors because all dental services were subcontracted under the MCOs.

In order to streamline that process, their medical codes were rolled into dental which could now possibly fall under My Rewards. So, we want to ascertain that those services are still under the MCOs. These codes would relate to fistula closures, removal of benign and malignant lesions, incision and drainage of infections, removal of foreign bodies, osteotomies, wound suturing, surgical procedures including tracheotomies, palliative treatment, anesthesia and sedation.

And I think you can see if you were to arrive at an oral surgery office swollen and needing an incision and drainage and finding out that you didn't have enough points in you're my Rewards Program to achieve service, it would be a nightmare.

The oral surgeon member of the TAC states that it is not financially feasible to have a staff member to handle the additional paperwork that most offices see as necessary for participation in the My Rewards Program.

In addition, if providers can't

see the amount the member has available, it's a shot in the dark to develop and implement a treatment plan on that patient.

You made a comparison to commercial insurance companies. If we are members or are participating providers in Delta or Humana, we can go online, see how much that patient has available for the year and how much of that benefit they've used and how much they have remaining.

Also for services that are limited procedures, we can determine whether they have used up that limit for the year or whether they still have that available, but it's my understanding that the provider will not be able to see the amount that is available in My Rewards.

So, as I was saying, if you've got a patient in your face with pain and swelling, that this puts the provider in an untenable position and sometimes referral to the nearest emergency department will become your best option at a considerable higher cost. And basically that ends in a lose/lose situation because the patient will be penalized for inappropriate use of the ED and the system ends up paying out more for services.

Our TAC member states that if

these codes remain in the My Rewards Program, his office will be closed to adults as of July 1, 2018. This sentiment is shared by all oral surgeons who have contacted the TAC, as well as large group practices such as Mortenson's which represents over thirty dental offices.

It is unclear whether provider participation in My Rewards Program will be mandatory if you are a Medicaid provider. If so, these providers which includes all oral surgeons will no longer be Medicaid providers, thus, threatening the existing networks.

General dentists will be reluctant to approach anything except the easiest cases if they are without oral surgery backup. Having a case morph from a planned, routine extraction into an unplanned surgical extraction is not a rare occurrence.

This recommendation is made with the interest of maintaining the existing provider networks which were so painstakingly crafted by the MCOs, as well as maintaining access to care.

The provider forums indicated that one of the goals of My Rewards Program is conserving and improving access to care. If these

codes are not carved out of the My Rewards Program, it will be difficult to reconcile the stated goal with the structure of the program.

And I received a text while I was here. Hold on just a minute. The Chairman of the Emergency Medicine Department at UK Medical Center supports the TAC position on keeping surgery codes with MCOs.

He, plus the Dean of U of L Dental School, KOHC which is the Kentucky Oral Health Coalition, KPCA, Somerset Hospital, oral surgeons and others all sent letters supporting this to Commissioner Miller, Secretary Adam Meier and Deputy Secretary Putnam.

Also, doctors at each provider forum supported this. They say--oh, you can't say that you haven't gotten provider feedback.

Now, we also have a second recommendation. Section 6(g) of the MAC bylaws promulgated on January 25, 2018 requires video teleconferencing if necessary to achieve a quorum for the TAC meeting. Arrangements for the same have proved to be quite unwielding.

The Dental TAC recommends that Apple Facetime, Google Hangouts, Skype or other

digital equivalents be considered acceptable alternatives to accomplish this requirement. The TAC Chair or Vice-Chair should be present physically to verify attendance and conduct the business.

DR. PARTIN: Thank you. Nursing Home Care.

MR. TRUMBO: KAHCF has nominated two new members to the TAC and plan to confirm them at the next TAC meeting.

DR. PARTIN: Thank you. Home Health.

MS. STEWART: We had a quorum at our last meeting and we have no recommendations at this time.

DR. PARTIN: Hospital.

MR. RANALLO: I'm Russ Ranallo. I'm the Chair of the Hospital TAC and Vice-President of Finance at Owensboro Health. I think our recommendations are in your packet but I'm going to go through them relatively quickly.

We met on May 8th and we had a full TAC meeting. It was the most well-attended TAC I can remember with everything that's going on.

The MCO problem list. Every month, KHA meets with the MCOs and goes through an

open problem list. They are tracked over time. We have a variety of performance based on the MCOs. We have some MCOs that have zero issues on the list. We have some that are improving and some that are deteriorating.

My graphs didn't make it into the packet but we'll get you those, but the recommendation is the Cabinet would use provider input when it scores the proposals they receive when they re-bid the contracts in 2019 based upon these problem lists and the performance of the MCOs.

IMD. I know IMD has come here before. There's been formal recommendations by the Hospital TAC and the Behavioral Health TAC in the past and it continues to be an issue.

Anthem, Aetna and Passport have implemented it. Humana is going to implement it July 1, but WellCare still hasn't implemented it and we're talking about two years plus on the IMD.

So, the TAC believes that when there aren't any other beds available, this shows an inadequate network and the MCOs should be required to pay for out-of-network care to the freestanding psych hospitals.

So, the recommendation is the

Cabinet review the network adequacy of WellCare for behavioral care as the lack of implementation of the IMD continues to be an issue across the state.

On the 1115 waiver, we've had a lot of meetings with the Cabinet's implementation team. They have been very productive. They have been well-attended by all constituencies and we appreciate them very, very much.

We still have about four pages or so of unanswered questions and we're close to the July 1 date.

One of those things that was talked about today was payment of premium. The hospitals, the providers, we want to take not only the credit cards or we want to be able to take a check and cash, if I've got somebody in front of me who is filling out an application and they have their premium, I want to be able to take and process that.

It makes no sense for us to assist them through that process - and all of my people are certified financial counselors and are certified to help - to say to that patient, okay, you've got to go across town to Kroger to pay that premium, they may never get there. We would rather do that as providers.

And you've got one MCO, Passport, they've got two offices across the state right now where cash can be paid. So, if I've got a Passport patient and all they have is cash, I'm sending them to Louisville? It's just not reasonable.

So, the recommendation is the Cabinet work on the outstanding waiver questions with the providers and the MCOs.

Auto assignment. This has been brought up here. It continues to be an issue and I will give you a real-world example from a provider who had a patient. I mean, you've got twenty critical access hospitals around, ten sole community hospitals. So, they're the only hospitals in that area.

She may have other hospitals in the region with an MCO, but, realistically, if that hospital, that critical access hospital is not with the MCO, that patient is out of network for the thirty-mile radius.

You had a patient that came to the ED, was auto-assigned to a plan that the hospital did not participate with, had issues, was referred to a heart surgeon. The heart surgeon evaluated that

patient and said that patient needs surgery. The MCO would not give the provider authorization -it was an out-of-network hospital - to do that surgery.

The surgeon goes back and says that patient can't wait two weeks to travel thirty miles to have that heart surgery and then it's a scramble, a manual scramble to get peer to peer, to try to get that patient taken care of.

So, the DMS knows. They have the information where those providers are not with an MCO. The TAC recommends that the information be incorporated into the auto-assignment algorithm and at a minimum prompt the Benefind system to require the patient when they're picking an MCO to say what is your hospital and here are the participating MCOs that are there because it creates a whole host of issues when you've got somebody that is trying to switch and then they do have a condition or they don't know. You've got split moms and babies. It continues to be an issue in certain areas of the state.

Equian audits. So, the Equian audits continue to be a problem. Essentially, you've got Anthem, Aetna and WellCare that have contracted with an auditor called Equian. They take outlier

cases and they ask for an itemized bill.

When they get the itemized bill, they strip out charges that they think should be in the room rate, that should be in a procedure code and they reduce the payment.

The way an outlier is paid, it's based on a hospital-specific cost-to-charge ratio. So, how a hospital charges is already taken into account in that payment mechanism.

We have been told by DMS to take it through the SB 20 process. I've taken one. It's not worked. It's built for a medical necessity review. This isn't a medical necessity review. It's a bill audit. It's a billing audit, plain and simple.

So, we got denied because we didn't send in medical records on a medical necessity review that wasn't a medical necessity review. So, now I'm looking at an Administrative Law hearing for one case and I've got about sixty others behind me, but this isn't just me. It's every hospital, every big hospital in the state.

So, the TAC recommends that DMS disallow Equian's policy related to bundling of charges rather than placing the administrative burden

on the hospitals to individually appeal each denial.

OPRA, Ordering, Prescribing, Referring, Attending. So, when I send in a bill, if I have any one of those providers on the bill, I have to make sure that the NPI matches and the taxonomy matches what's in the State file.

I can look up the NPI but I can't look up the taxonomy. So, I'm guessing or I'm getting what their office is telling me and a lot of times what their office tells me, the office manager tells me is not what they put on their application and their file to Medicaid when they got credentialed.

So, I'm getting denials because of taxonomy mismatches with the State file and I can't look and see what's in the State database on taxonomy.

Indiana went through this. They got rid of the taxonomy. We asked for that, to get rid of the taxonomy requirement. We were turned down.

So, the recommendation is in lieu of not eliminating the need to include the taxonomy code, the TAC recommends that Kentucky Medicaid provide a way for hospitals to see the

taxonomy code on file with the Cabinet so that I can get my bills correct. These are independent providers. It's not something I have control over and there are a lot of sub-categories. So, you may think it's internal medicine but they've classified them a sub-taxonomy.

Coding and medical necessity criteria. We've had questions raised about what criteria MCOs are using to review coding decisions.

The real-world example was you had a hospital that used the CMS and AHA coding guidelines to code a diagnosis. The MCO denied that diagnosis based on a World Health Organization journal and it was taken through medical review and the PRO and they upheld the MCO's change of it.

So, the recommendation is the Cabinet, in addition to specifying the source of the medical necessity, that it specifically states that coding should follow CMS guidelines in the MCO contracts.

It's different rules. Tell me what the offenses are and what the rules are but you can't change them on me. As soon as I use that World Health Organization diagnosis, I guarantee you that that MCO will come back and say, no, the AHA and the

CMS guidelines apply here.

So, if we're going to start using journals to code claims rather than what CMS has approved, then, I need to know.

And the 340(B) hospitals versus reporting NDC's. So, this goes back almost a decade. Other states have done this that allow those in the 340(B) program that agree with CMS to bill Medicaid from having to report NDC's on their claims.

We get a lot of problems with NDC's. We get a lot of denials for NDC's and sometimes they're not just line-item. They're claim denials, but a lot of things happen. We were using the NDC. We think it's an appropriate NDC for the actual dose. They're using an NDC from a box, from a case and which one is right from the MCO perspective.

And from my view - we've gone around and around about this - Kentucky doesn't get any additional rebates from these 340(B) hospitals using that NDC. So, we have other states that do that.

So, the recommendation is that the Cabinet establish a deadline to resolve this issue. It's been one that's been on there as long as I can remember and it's been stagnant for a variety

of reasons but we need to get it moving again. Any questions? Thank you very much.

DR. PARTIN: Intellectual and Developmental Disabilities.

MR. CHRISTMAN: Hello. I'm Rick Christman. I'm a Co-Chair of that TAC.

We met on March 14th where we had a quorum and we passed the following motion: Whereas, individuals with DD/ID whose residential care needs cannot be reasonably met through the SCL waiver as it exists but who should also be provided services in the least-restrictive environment, the DD/ID TAC recommends that the Department for Medicaid Services develop a plan to close this care gap by modifying the services provided by the SCL waiver and ICF/MR services.

I think what initiated this conversation is that we have a lot of people in the SCL program who their needs are very difficult for us to meet. We also are aware there's probably people in the ICF/MR's who probably could benefit from community services if the supports were there.

Now, we just heard from our friends from Navigant. If we would have this individualized budget methodology, that might be a

very good way to address this need.

I also noticed in the budget that was just passed by the General Assembly that they're directing the Cabinet to transition all qualified persons who are living in ICF/MR model to a community living model. Again, I think if we adapt this individualized budget, if the Department would consider that, that might be a good way to substantially reduce the number of people in the ICF/MR facilities and overall save money.

The second recommendation, and we've already talked about this, whereas, there are a number of SCL slots authorized by the General Assembly that have not been released presumably because of funding issues, the DD/ID TAC recommends that the Department for Medicaid Services secure the necessary funds to release these authorized but unfunded slots as soon as possible.

So, again, we can authorize all the slots we want to, but if we don't fund them, then, we're really not addressing the waiting list.

Finally, I would just like to mention, too, we had another meeting just recently on May 7th in which the topic was the implementation of the rate increases for the SCL program which the

General Assembly has provided for a 10% rate increase for the SCL program which we're very pleased about.

However, we learned that there's some question as to when that would be implemented. It may not be July 1st. And, so, just' speaking as a member of the organization I represent on the TAC, KAPP, that we would urge the Department to implement this rate increase as soon as possible through an emergency regulation.

So, thank you very much. Are there any questions?

DR. PARTIN: Thank you. The Nursing TAC did not meet. Optometry.

DR. COMPTON: Yes. We met on May 10th. Everyone was there and we have two formal recommendations for consideration.

Number one, we would hope that prior to July 1st, the TAC requests a vision provider-specific forum to address the handling of the My Rewards Program within Kentucky HEALTH.

There are many questions still surrounding the handling of routine versus medical vision services in Kentucky HEALTH. A brief forum focused specifically on the My Rewards Program and how these are reflected and handled within the

provider portal and then Citizen Connect will resolve a multitude of issues for providers and the Cabinet a like, Vision providers are committed to the success of Kentucky HEALTH but we must be equipped with clear information prior to July 1st.

Our optometrists who serve on the Medicaid TAC have provided assistance and feedback throughout the application and implementation process to DMS representatives.

We remain committed and are encouraged with the work that has taken place by the Cabinet, specifically the efforts made with the provider forums throughout the state.

However, many questions still remain such as the basic determination of what is deemed a routine vision service, the handling of negative balances within My Rewards, along with multiple other billing and coverage questions. If clear answers are provided at this specific forum in advance of implementation, all parties will benefit.

The TAC has continued to emphasize the importance of clear communication to the adult able-bodied expansion population who must utilize the My Rewards Program on this confusing

issue. Perhaps most importantly, the forum will help give providers consistent communication that they can give to the impacted population that they serve.

And recommendation number two is a specific request regarding future processing of claims by the MCOs, and we adopted this before we knew the RFP's were going to be delayed until later this fall but it still applies.

With the implementation of Kentucky HEALTH, the Department has deemed it appropriate to differentiate between routine vision services and medical services and the Department intends to separate these two types of services based upon CPT codes used by the provider.

The Department has deemed some CPT codes as routine vision and some as medical primary care codes. As it relates to the processing of the Medicaid claims outside of Kentucky HEALTH, there is often a great deal of confusion when medical claims are sent to the secondary vision providers and vice versa.

The TAC would like to require that the Department put in future MCO contracts that all medical claims, now that we have clear codes that have been established, must be processed by the MCO

medical carrier, and all routine vision services and materials claims, now that clear codes have been established, must be processed by the secondary vision providers or the subcontractors. This is how it's handled with commercial plans and will greatly reduce confusion and increase efficiency for all the parties involved.

And I'll answer questions if there are any. That's all of my report.

DR. PARTIN: Thank you.

Pharmacy.

DR. FRANCIS: I'm Suzi Francis. I am the new Chair of the Pharmacy TAC. I was previously Vice-Chair.

So, I'm here today with two recommendations. I know they're not in your packet but they will be emailed out to you this afternoon.

The Pharmacy TAC met on May 18th and all five members were present. So, we had a 100% unanimous vote for these two recommendations.

So, the first one is about Naloxone. So, Kentucky has a valuable resource in our community of pharmacists throughout the state. As you know, we also have an opioid addiction problem with 115 people dying per day of opioid overdoses.

So, the U.S. Surgeon General has asked to expand the availability of Naloxone within community members to help prevent death. And the PTAC recommends that the Department for Medicaid Services review the legal statutes that recognize pharmacists as health care providers.

So, I won't name the statutes. They'll be in your packet, but in Section 23 of KRS 304, this particular section defines pharmacists specifically as health care providers, and Naloxone education is mandatory upon dispensing of Naloxone. However, pharmacists are not paid for their time for these cognitive services.

So, based on our legislation, the PTAC recommends that we believe pharmacists have a legal right to provide and bill for a Naloxone education using CPT Code 99408.

As other providers can use for this code for reimbursement, the PTAC recommends that DMS and Medicaid recognize and further define pharmacists' provider payment codes to assist the MCOs and the fee-for-service payments for cognitive medication services such as MTM or medication therapy management and to include the fee-for-service payments for the dispensing of Naloxone.

Another state, if you wanted to look at a model example state, New Mexico has enacted this through Optum where pharmacists can populate the NCPDP incentive amount field and pharmacists are paid $37.50 for the education along with a Naloxone dispensing.

So, our second recommendation is also concerning the accessibility of pharmacists. So, it allows citizens to have a greater access to our Vaccines for Children Program. So, pharmacists legally can be providers in the Vaccines for Children Program, however, DMS is not paying the administration fee for vaccinating children to pharmacists at this time.

So, this currently is an urgent matter with the Hepatitis A outbreaks in the state. So, pharmacists have contacted the TAC members and have explained that they're having to turn away patients because they are not providers of Vaccines for Children.

So, Vaccine for Children, as you probably know, requires a lot of paperwork, a lot of logistical efforts, and the minimal $3.50 admin fee should be paid to pharmacists if they're going to enroll and be providers in that program.

So, it is brought to the attention of the MAC at this time with urgency because many children are needing the Hep A vaccine as Kentucky is currently faced with outbreaks, as I said.

In addition, the school immunization regulations require all children to receive Hepatitis A and Pneumococcal vaccines by July 1st.

Furthermore, Kentucky ranks as the number one state for HPV-related cancers and the American Cancer Society, the CDC and the Kentucky Department of Public Health have strategic plans on going to improve HPV vaccination rates. Both Hep A and HPV diseases are very preventable through vaccine. However, immunization rates remain very low.

So, the PTAC would like for the Department of Public Health to see what measures need to be put into place for pharmacies to be paid the admin fees for Vaccines for Children Program, increasing the accessibility of these vaccines and improving immunization rates.

So, as the Commissioner explained earlier today that we are on a very tight

budget and we understand that and we're asking the MAC to leverage our accessible resources and pharmacists throughout Kentucky. Although the PTAC is recommending payments to pharmacists as providers, we recognize the total cost of care will be much reduced long term.

For example, if a $3.30 administration fee prevents even one case of Hepatitis A, thousands will be saved, and a $37.50 education fee to pharmacists preventing an emergency department visit would be helpful. Any questions?

MR. CARLE: Suzi, is that the first time that this recommendation has been made from the TAC or has this re-heated?

MS. FRANCIS: To my knowledge, we did amend these. We had these together but we had not met before this May meeting since August. And, so, to my knowledge, this is the first time. I'm replacing Jeff Arnold.

MR. CARLE: Great. Thank you.

DR. PARTIN: Thank you.

MS. HUGHES: If you could email me those recommendations.

DR. PARTIN: Physician Services.

DR. McINTYRE: I'm Dr. William McIntyre. I'm the Vice-Chairman of the Physician TAC.

We have no action items. We met six days ago with Medical Directors of the MCOs, with members of the Department of Medicaid Services, with Dr. Liu.

We're pleased with the progress the Department and the MCOs are making on clearing up the backlog of provider applications. We look forward to the implementation of the uniform credentialing under House Bill 69.

We had presentations from the Department on telehealth, on the Medicaid 1115 waiver program, tobacco cessation. All five MCOs are paying for translation services which we're pleased with.

We're also pleased with the work of Dr. Samantha McKinley and her staff. The Centers for Disease Control implemented new recommendations recently on narcotic prescribing, and Dr. McKinley and her staff are working on establishing rules on Naloxone use, prior authorization and so on for providers, and the TAC supports those efforts.

Any questions at all from

anybody?

DR. GUPTA: Dr. McIntyre, were all the MCOs providing the translation services free of service to the provider? My understanding is there were one or two that are still charging the provider. Like, Passport, I believe, is still charging the provider for providing translation services.

DR. McINTYRE: Yes, that's correct. Passport does that.

DR. PARTIN: Thank you very much. Podiatry. Primary Care.

MR. BOLT: Good afternoon. David Bolt representing Chris Keyser, the Chair of the Primary Care TAC. We did meet on May 10th with a quorum present.

I won't bore you with the details we submitted. It's not really recommendations but it comes under the auspices of public comment that we wish to be passed along.

We do want to express our appreciation to the Commissioner and his staff for making some major progress on some long-existing problems and concerns affecting the clinics and primary care in general.

DR. PARTIN: Thank you.

Therapy Services.

DR. ENNIS: Good afternoon. I'm Dr. Beth Ennis, the Chair of the Therapy TAC. I apologize that we haven't been here for the last couple of meetings.

No new recommendations; again, more of a public comment just to express some frustration because we have been waiting on some things to try and move forward and it just hasn't happened. There's been a lack of communication, lack of feedback.

We've been asking about a same-day signature regulation for the last year, I believe, and we've had no updates on it.

We have had a trial with some third-party administrators with two of the MCOs looking at the authorization process, the precert process and that has not been going very smoothly, but it's interesting that it's the same third-party administrator with two different MCOs and we're getting two different situations. It's working well with one but not with the other and it's supposedly the same people.

So, we're still trying to

figure that out, but between that, we have codes that get put back on the fee schedule when it's updated that are incorrect again and it's kind of like a Groundhog Day situation where it takes six months to get those fixed.

We don't get any information on are they changing the codes, are they not changing the codes. The MCOs go by the codes that are on the website. And, so, it takes us six months to get them changed and then people don't get paid.

So, we're losing providers, specifically those that treat children which is going to be a challenge because, even though the provider rolls look like they have a lot of therapy providers, they're generally ones that will treat adults. And, trust me, you don't want me working on your spine and you don't want one of them working on your child.

So, if there's a way to tease that out, it would be nice to be able to say this is going to be a problem moving forward, especially with that vulnerable population.

So, we just wanted to express our concern with frustration and with lack of communication. We seem to be spinning our wheels doing the same thing month after month.

We met on May 8th. We did have a quorum. Sorry. I should have said that up front. Thank you.

DR. PARTIN: Thank you. We're getting into a bit of a time crunch.

Under New Business, the MAC election will take place this coming July. So, any members of the Council who wish to run for office, please submit your name to me and to Sharley and, then, we can put you on the ballot. We have to have the ballot prepared thirty days ahead of time. So, if you're interested, you need to submit that by mid June.

And, then, the next items on the agenda were items that Jay asked us to include. And, so, would you like to speak to those?

MR. TRUMBO: We just had some questions about the level-of-care systems. I saw Lee had to leave, but is there anyone here that can answer?

MS. HUNTER: Jill Hunter, Deputy Commissioner of Medicaid and Lee reports in to me. So, I can share what I know on the KLOC system, what we're unofficially calling the KLOC system, Kentucky Level-of-Care system because we put "K" in

front of everything, so, our KLOC system.

At this time, everyone is going to our new reg writer and telling him that we're the most important kid in the room. I'll continue to fight for our long-term care and our 1915's but I'm going to stand right behind the 1115, I think, and respectfully so.

So, going forward with the regulations, we're very excited about that product. It will go to CMS; and with all due respect, they are on their own timeline, but, yes, the KLOC system is moving forward.

Every new system has hiccups. So, bear with us. We work closely with KHCF and with Mr. Veno's group, both. We'll continue to do so.

As for the other questions, so I follow protocol correctly, I believe I have to take them in this meeting and then give you formal written answers, but what I can tell you is the systems will continue.

We have folks through Lee's shop in Policy. We also have the DCBS staff that are assigned just to long-term care due to the ins and outs the way long-term care recipients transition in and out from the system.

They will continue to wrap around all long-term care providers as they have. I believe we've been doing that for close to three years now and that won't change. We're hoping KLOC's will eliminate the need for so many staff, but if it doesn't, we'll continue.

And, then, Mr. Johnson explained to me at the beginning of the meeting that Lee is going to sit in with your finance committee and be able to answer more questions. Thank you.

MR. TRUMBO: Thank you.

MS. HUNTER: Thank you, Dr. Partin.

DR. PARTIN: Thank you. I thought this was going to be long.

Did that answer everything that you needed, Jay?

MR. TRUMBO: Yes.

DR. PARTIN: Okay. So, that wraps up everything we have on the agenda unless any Council members have something that you would like to bring forward.

Motion to adjourn?

MS. CURRANS: I make that motion.

MR. CARLE: Second.

DR. PARTIN: We are adjourned.

MEETING ADJOURNED